Testimony
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Patient Safety Activities at the Department of Health and Human Services

Statement of
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Chairman Deal, Congressman Brown, distinguished Subcommittee members, thank you for inviting me to this important hearing on initiatives to improve the safety of patient care in America. Patient safety is a high priority for President Bush and Secretary Leavitt; it is a statutory responsibility for my agency, the Agency for Healthcare Research and Quality (AHRQ); and it is a key area of emphasis for agencies across the Department of Health and Human Services and other Federal Departments. The Administration remains supportive of passing patient safety legislation that protects and encourages error reporting without fear of litigation and looks forward to continuing to work with the Committee on this important issue.

Congressional Direction

It is now more than 5 1/2 years since the Institute of Medicine (IOM) elevated national awareness of the issue of patient safety with its landmark report, *To Err Is Human.* Since then, the issue of patient safety has become almost inescapable. Nearly every week, newspaper articles, reports on the radio and television, and articles in the medical literature keep issues of patient safety in the national spotlight.

The IOM report was a critical turning point. It changed the way the public sees the health care community, and the way the health care community sees itself. It essentially "changed the conversation" in two essential ways. It made us realize that when medical care goes badly, the traditional response of "name, blame, and shame" not only does little to improve safety for the next patient, it may actually put

the next patient at greater risk by encouraging mistakes to be hidden. The IOM also reminded us that safe, high quality care requires a team effort; patient-centered care requires tremendous ongoing communication and collaboration, requiring adjustment in our ongoing trend to greater specialization.

It is worth noting that congressional action to promote patient safety actually preceded the November 1999 release of the IOM report. During the summer of 1999, Mr. Chairman, your Subcommittee included a mandate to address medical errors in the bill reauthorizing and renaming my agency. Appropriations followed a year later, with a directive from the Senate Appropriations Committee for AHRQ to lead a national effort to combat medical errors and improve patient safety.

Mr. Chairman, this hearing is especially well-timed. It coincides with the annual patient safety conference AHRQ hosts for the researchers we fund, health professionals and the public. These annual conferences are designed to assess progress and accomplishments, promote better coordination and foster mutual learning. Because we made a significant number of health information technology awards last year, many of which were related to patient safety, we expanded this conference to include a dual focus on patient safety and health information technology. We focused on patient safety on Monday and Tuesday, had a general plenary session on Wednesday that was keynoted by Secretary Leavitt, and today and tomorrow will highlight health information technology.

Department-wide Commitment

I will address how AHRQ has responded to congressional direction in a moment. It is important to note at the outset that the response to the challenge of improving patient safety is shared Department-wide. For example, MedWatch, the Food and Drug Administration's (FDA's) Safety Information and Adverse Event Reporting Program, provides important and timely clinical information about safety issues involving medical products, including prescription and over-the-counter drugs, biologics, devices, and dietary supplements. FDA has issued a final rule requiring the bar coding of most drugs to promote electronic prescribing and to reduce the number of medical errors that occur in hospitals and health care settings. FDA's MedSun program of 2-way communication between FDA and health care facilities is improving the identification, understanding, and sharing of information about medical device problems. It is currently being used to pilot tissue surveillance. In addition, FDA is working on an integrated reporting system to allow reporters to submit an adverse event report about any FDA-regulated product through a single gateway and website. FDA is also working on human factors engineering to make medical devices more user-friendly and to eliminate device errors that cause harm.

The Centers for Medicare & Medicaid Services (CMS), in collaboration with the Centers for Disease Control and Prevention (CDC), AHRQ, and many private sector partners, has launched a

major patient safety initiative, the Surgical Care Improvement Project, to eliminate surgical complications, such as post-operative pneumonia and surgical site infections. This work builds on the National Surgical Improvement Project begun in the Department of Veterans Affairs (VA), tested in civilian hospitals through support from AHRQ, and now being implemented nationwide through Medicare's Quality Improvement Organizations (QIOs).

The CDC maintains a sentinel network of hospitals, the National Nosocomial Infection Surveillance (NNIS) System, and has launched a Campaign to Prevent Antimicrobial Resistance in Health Care. Monitoring infections, antimicrobial resistance, disease-specific screening and preventive healthcare practices, and other health events is a proven prevention strategy. In addition, CDC funds Prevention EpiCenters (academic medical centers) to conduct research to prevent healthcare-associated infections and improve patient safety.

AHRQ Response

Since FY 2001 AHRQ has funded over 225 patient safety and related health information technology projects. These projects fall into four broad approaches:

- Identify medical errors and other threats to patient safety and understand why they occur;
- Advance our knowledge of practices that will effectively reduce or eliminate the occurrence of medical errors and minimize the risk of patient harm;

- Develop, assemble, and widely disseminate information on how to implement patient safety best-practices; and
- Enable providers to continually monitor and evaluate threats to patient safety and the progress they are making.

Our projects address a broad array of issues linked to preventing risks to patient safety: advancing the effective use of health information technology, an issue of particularly high importance to President Bush and Secretary Leavitt; medication safety; communication issues within the health care team and availability of patient support; error prone clinical practices; problems that arise because of an institution's internal culture or organization; provider fatigue; unique safety issues in intensive care units**,** issues related to education and training; and reporting of adverse events or near misses.

Advancing Patient Safety

Increasingly, our projects have emphasized the development of skills to undertake patient safety improvement, development of practical tools to facilitate the use of what is now known, and working in voluntary partnership with public and private sector groups to actually implement that knowledge. I will briefly describe projects in these three areas.

Developing Skills to Implement Patient Safety Initiatives

AHRQ has created a Patient Safety Improvement Corps, a training program that brings together teams of state officials and private

sector providers to learn and work together and undertake joint patient safety initiatives. The VA has partnered with us in carrying out the training sessions. Thirty-three states and the District of Columbia, 13 of which are represented on this Subcommittee, have participated in the first two years of the program. In recruiting for the third class we are giving preference to applications from States that have not participated.

Some teams have been successful in developing projects involving a large number of providers. For example, the Georgia team involved 28 hospitals and health systems across the state to develop and adopt strategies to ensure that the correct site has been verified before a surgical procedure is begun on a patient.

Another initiative, with the Department of Defense (DoD), is built on the recognition that teamwork is a critical aspect of patient safety. Poor team coordination is a major cause of preventable patient harm. The DoD and AHRQ have developed a public domain curriculum for training health care professionals to improve teamwork. This curriculum has been extensively field-tested and will be made available to all health care institutions nationally in the fall of 2005. AHRQ and DoD will be working with CMS and the QIOs to set up a national training program in teamwork using the new curriculum. The curriculum will also be available on the AHRQ PSNet (http://psnet.ahrq.gov/).

It is important to increase the skill level for analyzing patient safety threats at the hospital level. The most common approach in hospitals is known as Morbidity and Mortality, or M&M, conferences to assess what went wrong in cases where a patient was harmed. We have built upon that approach with a popular web site, known as the AHRQ Web M&M (http://www.webmm.ahrq.gov/) in which new cases are shared, along with expert commentaries on how to think through such cases, identify problem areas and potential solutions. Each month a "spotlight" case is presented, accompanied by an educational slide set that health professionals can download and use as an educational tool in their own institutions. More than 10,000 health care professionals are now ongoing registered users of Web M&M, and 28,000 visited the site in a recent month. This approach is bringing lessons learned about patient injury and medical error outside the confines of individual hospitals, and the users include nurses, pharmacists, physician assistants and other allied health professionals in addition to physicians.

Communication with patients is another important skill, especially when an error has occurred. One of our grantees, the Partnership for Health and Accountability, comprised of the Georgia Hospital Association (GHA) and Emory University, has developed a video, *Discussing Unanticipated Outcomes and Disclosing Medical Errors,* to assist providers on effective approaches for disclosing medical errors. The videotape was evaluated and refined and distributed to all GHA members. Over two dozen workshops were held throughout Georgia, to discuss the content of the video and to distribute a

questionnaire to ascertain hospital disclosure practices. Distribution of the video is available at no cost through the PHA website (http://www.gha.org/pha/).

Developing Tools to Improve Patient Safety

In response to requests by state hospital associations, state data organizations and others, AHRQ developed a set of indicators that any hospital can run against its hospital discharge data set to evaluate how it is doing in terms of safety and quality. The AHRQ Patient Safety Indicators are being used by a variety of hospitals and other organizations to screen for suspiciously high rates of potentially preventable complications from surgery and medical care, such as complications of anesthesia or postoperative infection.

Because the AHRQ indicators can allow for comparisons between hospitals, they are being used by a variety of organizations for public reporting and private and public sector pay-for-performance initiatives and demonstrations, in addition to internal hospital quality improvement. Many State and regional hospital associations, including the Georgia Hospital Association and the Dallas-Fort Worth Hospital Council, have integrated the AHRQ indicators into their quality improvement programs. A number of Blue Cross plans are using these indicators to align financial incentives with achievement of specific performance objectives, and some of the indicators are being used by CMS as part of their pay-for-performance demonstration.

Public and private sector organizations, such as Premier, Inc., have recognized the importance of measuring organizational conditions that can lead to adverse events and patient harm. To assist in that effort, AHRQ developed and recently released, in collaboration with DoD and Premier, another tool, known as the Hospital Survey on Patient Safety Culture. This public domain tool is being rapidly adopted across the country. For example, Catholic Health Partners has 70 hospitals in their system. They are using the survey and have received so far about 3,000 responses. DoD anticipates using it in all of its facilities world-wide and AHRQ has made it available on our patient safety website PSNet.

Voluntary Partnerships to Improve Patient Safety

The largest initiative, developed by the Institute for Health Improvement and cosponsored by AHRQ, CMS, and CDC, is the 100,000 Lives Campaign. This campaign has enlisted more than 2,200 hospitals to commit to implement changes in care that have been proven to prevent avoidable deaths. The initiative is starting with six interventions: deployment of Rapid Response Teams, delivery of evidence-based care for acute myocardial infarction, prevention of adverse drug events, prevention of central line infections, prevention of surgical site infections, and prevention of ventilator-associated pneumonia. The goal is to save 100,000 lives annually that would otherwise have been lost without these changes in the delivery of care. In addition to saving lives, the benefits of preventing complications are significant. For example, patients on ventilators are very susceptible to pneumonia because it is easy for

bacteria to get into the lungs. If they develop pneumonia, they are likely to spend an extra week in the hospital, and the extra cost of care can easily reach $40,000.

An AHRQ grantee at Johns Hopkins University is paving the way for success of the 100,000 Lives Campaign by working to prevent deaths resulting ventilator associated pneumonia and blood stream infections related to central lines. The Hopkins team is now working with 127 Intensive Care Units (ICUs) in Michigan, 30 in New Jersey, 45 in Maryland, and recently expanded into Rhode Island. Michigan's experience suggests the significance of what can be accomplished. An Associated Press story last week noted that Michigan hospital officials estimated that they had saved 77 patients' lives: 73 from pneumonia and 4 from blood infections. In addition, a small number of ICUs have actually gone as long as 9 months without one of these two complications. This project has developed implementation tool kits to assist other hospitals in putting these safety improvements into practice.

Building upon our research investment over the last 5 years, this week AHRQ awarded over $8 million in funding for 15 projects that are designed to help clinicians, facilities, and patients implement evidence-based patient safety practices. These grants, Partnerships in Implementing Patient Safety, will use existing knowledge to improve the safety of patient care. They are projects that will have both an immediate and a long-term impact. Over half the projects focus on reducing medication errors, an area known to be in need of

patient safety solutions. Many of the projects will apply interventions to improve health care team communications, also a well-known source of errors.

There are two key elements to these projects. First, the interventions are generalizable; they will work in a wide array of other settings of care. Second, like the Johns Hopkins grant described previously above, these projects will develop implementation toolkits that will share lessons learned on how to best implement patient safety practices, identify the barriers they are likely to face as well as ways to work through them. The implementation toolkits will be available on PSNet.

Concluding Observations

Mr. Chairman, we have made significant progress since the Congress and the IOM highlighted the importance of patient safety. But we are still a long way from the lofty goals reflected in the IOM report. So there is more to be done. I am reminded of the final slide of the Patient Safety Improvement Corps team from Georgia, during a presentation reviewing their experience, which said: “Patient safety is a never-ending process.”

I would like to conclude with several brief observations from our work that I hope will prove useful.

First, a culture of safety is critical on two levels. Health care professionals need to feel safe to honestly acknowledge errors or

"near misses" within the institutions in which they practice. Institutions also need to feel safe to seek help in identifying and resolving organizational and system-based threats to patient safety without retribution.

Second, as a culture of safety develops within an individual institution, it is important to recognize that the number of "reported" errors is likely to rise as previously hidden errors are disclosed. For this reason, an initial rise in the number of reported errors is a sign of success, not failure.

Third, while an increasing number of hospitals are developing the capacity to analyze the causes of medical errors, we need to recognize that the ability to conduct these analyses is uneven, both in terms of experience and skill level. One of our state Patient Safety Improvement Corps teams determined that, after excluding a large hospital with a pro-active patient safety program, most hospitals in their state completed only four root cause analyses per year. State teams that focused on the skills needed to undertake such analyses found that the need for better skill development was significant. Moreover, few institutions have any experience with other pro-active risk assessment methods. Moving to a system in which hospitals routinely undertake analyses of the causes of errors will require significant skill development and technical assistance.

Fourth, knowing the right thing to do to improve the quality or safety of patient care is only the first step. To increase the pace of

improvement, the emphasis on implementation research, step-by-step guidance on implementation, and tools to facilitate the use of effective interventions is critical. AHRQ has already begun shifting its emphasis within our existing resources in this direction.

Fifth, there is a significant amount of information on how to improve the safety of hospital care, but the evidence base is less robust for other settings of care.

Finally, as a non-regulatory agency, I believe that AHRQ can make effective use of voluntary collaboratives that bring together health care organizations at different stages of development in the application of effective health care interventions. Collaboratives provide a natural setting for shared learning which accelerates the pace of improvement and innovation. By providing an opportunity to learn from the experience of organizations on the cutting edge, we can eliminate the inherent delays that occur while each institution reinvents the wheel. This approach also enables AHRQ to better focus its technical assistance and short-term implementation research.

Mr. Chairman, that concludes my prepared remarks. I would be delighted to answer any questions.